INFORMATION SYSTEMS ADVISORY COMMITTEE

August 8-9, 2007

BI-ANNUAL MEETING

Portland Area Office

Edith Green-Wendell Wyatt Building
1220 SW Third Ave, Conference Room 322
Portland, Oregon

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Participants

ISAC Members Attending

Michael Belgarde, IHS, Navajo Area Office
Theresa Cullen, IHS Chief Information Officer (CIO), Office of Information Technology (OIT), IHS
Richard Hall, Tribal, Alaska Native Tribal Health Consortium (ANTHC), Alaska
Ron Fondren (Bill Lance Alternate), Tribal, Chickasaw Nation Health System, Oklahoma
Madonna Long, IHS, Lower Brule Service Unit, Aberdeen Area
Clark Marquart, IHS Chief Medical Officer Representative, Portland Area
Wendie Murray (Don Kashevaroff Alternate), Tribal Self Governance Advisory Committee Representative, Alaska
Lois R. Niska, Tribal, Medical Director, Ni Mii Puu Health, Lapwai, Idaho
Reece Sherrill, Tribal Co-Chair, Choctaw Nation Health Services Authority, Oklahoma
Chuck Walt, Tribal, FonDuLac Reservation, Wisconsin, via conference call
Geoffrey Roth, National Council of Urban Indian Health Board (NCUIH) Member

ISAC Members Absent

Darren Buchanan, IHS Office of Environmental Health and Engineering (OEHE) Representative
JoLynn Davis, National Clinical Councils Member
Kathryn Lewis, IHS, Albuquerque Indian Health Center
Floyd Thompson, IHS, Gallup Indian Medical Center
Vacant, IHS National Council of Executive Officers
Vacant, IHS, Information Systems Coordinator Committee (ISC) Representative
Vacant, IHS Member (Vice Pat Cox)

Other Attendees

Mike Danielson, Director, Division of Information Technology, OIT, IHS
Charles Gepford, Deputy Director, OIT, IHS
George Huggins, Director, Division of Information Resources Management, OIT, IHS
Kathleen Federico, Director, Division of Information Security, OIT, IHS
Skip Leader, Choctaw Nation Health Services Authority, Oklahoma
Doni Wilder, Area Director, Portland Area IHS
Mechelle Johnson-Webb, Office of General Council
Barbara Hudson, Office of General Council
Leslie Racine, Statistical Officer Representative
Mark Carroll, Director, IHS Telehealth Program
Bernie Daillebоust, Director, Division of Enterprise Project
Bob Adams, Clinical Application Coordinator, Portland Area

Christy Tayrien, Business Systems Analyst, DNC Contractor

Roll Call, Welcome and Introductions

Reece Sherrill and Madonna Long, ISAC Co-Chairs

Reece Sherrill and Madonna Long, Indian Health Service (IHS) Information Systems Advisory Committee (ISAC) Co-Chairs, welcomed the attendees to the meeting and conducted a roll call. Participants introduced themselves to the committee and identified their positions on the ISAC or at IHS. The meeting's discussion items are summarized below.

Information Systems Advisory Committee Role

Reece Sherrill and Madonna Long, ISAC Co-Chairs

Reece Sherrill asked the ISAC to consider the Committee's role and its effectiveness and asked for the group to share their perspectives.

- Clark Marquart: The purpose and role have changed over time. When ISAC originated, Tribes did not have a voice. The IHS Information Technology (IT) priorities were being set behind closed doors and decisions were not really shared. The ISAC has contributed positively to bringing these decisions out in the open. The Department of Health and Human Services (HHS) mandates have been increasingly imposed on the IHS through no fault of the IHS Chief Information Officer (CIO). In terms of the ISAC, as long as the group feels it is still effective, there is a need for it.
- Rich Hall: The ISAC is supposed to be directing the IHS on priorities but cannot trump higher powers.
- Geoffrey Roth: Is the ISAC considered as "consultation?" The Office of Management and Budget (OMB) and HHS conducts consultation meetings but they do not have IT in the discussions.
- Dr. Cullen: The ISAC Charter does not have consultation in it and wanted to take it off the table for now.
- Dr. Cullen: The overhead costs of software development are now approximately 50 percent. Two areas the ISAC can make a difference are in the Information Technology Investment Review Board and the IHS IT budget.
- Wendie Langton: Agreed with Dr. Cullen, the ISAC needs to go back to looking at the big picture and not the day-to-day plan. The ISAC needs to report to Dr. Grim. One point of frustration is the group is not following the charter.
- Reece Sherrill: Does not see what the ISAC is saying as being taken as important.
- Dr. Cullen: It is important, but there are some things occurring internally that cannot be discussed with Tribes.
- Doni Wilder, Portland Area Director: Area Directors are very interested. She is working with an IHS assessment workgroup to address IT and other shortfalls. Areas are being charged for Headquarters IT shortfalls and Areas have to put off costs this year that they will have to address next year as a result. Some of the shortfall is due to no Headquarters IT residual. Ms. Wilder said she cannot remember the last time IT was discussed in a Tribal negotiation in her Area. Tribes are looking at direct health care, not IT. No Area wants to look at IT residual again after the initial difficulty in identifying residuals. But at some point it needs to be reexamined. This may be something Tribes want to add in their consultation with the HHS and OMB.
- Skip Leader: His Tribe is spending 10 times what they get for IT shares. Taking the shares was a migratory pattern; they weren't getting anything so they took a portion, then more.
- Dr. Cullen: Our direct sites are not getting what they need either. The bottom line is we do not have enough funds. Dr. Cullen gave the example of the Master Person Index being on the ISAC priorities for the last 5 years. It has been on hers as a clinician for the past 15 years.
- Skip Leader: Wants to be able to have these discussions with everything out in the open, the "can't talk about it" needs to be addressed.
- Geoffrey Roth: Urban programs are in a similar situation.
- Rich Hall: The ISAC role is one of advocating for IT to the IHS Director and sharing information.
- Dr. Cullen: IT is not a top 10 priority.
- Geoffrey Roth: Budget process does not work. Current administration is not listening.
- Madonna Long: As ISAC, we need to bring IT issues to the forefront. We are wasting government dollars on training. She discussed having to attend a lengthy mandatory training session where only 15 minutes of it applied to her role.
- Rich Hall: Read an article with the point being made that "Should have talked to IT first."
- Chuck Walt: Need to look at the percentage of the budget going to IT.
- Clark Marquart: Problem has been here long before Dr. Cullen got here.

Action Item: OIT will send ISAC the HIT workgroup volunteer message from Dr. Cullen.

Chief Information Officer Status Report

Dr. Theresa Cullen, IHS Chief Information Officer

See presentation slides located at: CIO_Update-ISAC_08-08-07(TC).ppt

Discussion

- Chuck Walt: Compacting tribes have to keep their eye on the security area. They are not in the loop on this right now.
- Dr. Cullen: We are trying to devise recommendations that meet the letter of the law but impose the least physical burden on the Tribal sites to meet the level of certification that the Feds have to meet.
- Chuck Walt: Funds will not be available, and we will also be lopping off a whole group that needs to be connected. The question would be what is the alternative?
- Dr. Cullen and Chuck Gepford: There is none.

Action Item: None

Patient Accounts Management System

Dr. Theresa Cullen, IHS Chief Information Officer

Chickasaw Nation is fully running PAMS without issue. Auto Posting has not been developed yet. Choctaw Nation has not implemented PAMS. They are having issues with the their test server not being set up identically to the Chickasaw Nation's live server, which is causing the Choctaw's to retest routines the Chickasaw's have already tested. Gila River's staff was being trained the week of July 30-Aug 3. The initial PAMS business case was presented at the IHS Information Technology Investment Review Board Meeting on May 10, 2007; however it is still not complete. The PAMS Licensee Agreement is being evaluated in IHS Headquarters Acquisitions.

Discussion

- Ron Fondren: Chickasaw Health Systems have fully implemented PAMS. They are still working on reporting issues.
- Reece Sherrill: Choctaw Nation Health Systems have done partial implementation.

- Reece Sherrill: Asked for the status on additional funding through the end of June referenced in the letter response from IHS to the Tribal Consortium. Dr. Cullen said the license agreement has to clear acquisitions before we can address funding. Her understanding is there will be a letter going back from Acquisitions to notify the Consortium they are internally evaluating it. Reece Sherrill said we are past our time frame from Deputy Director McSwain. He was asked by Mickey Peercey in Oklahoma to check on this.

- Madonna Long: Asked about the size of the Chickasaw Health System. Ron Fondren said it is a 54-bed hospital with 5 clinics. Reece Sherrill said Choctaw has 30 beds and several clinics. They have a different set up than Chickasaws since they have a central data base. Choctaws have to write code to make PAMS work. It's running in two clinics -- family practice and pediatrics at one site.

- Ron Fondren: Gila River is going through training.

- Madonna Long: Asked about Auto Posting. Ron Fondren said it has been fixed; have functional posting. Reece Sherrill said Choctaw is running a parallel system to post with.

- Rich Hall: Every month that goes by that PAMS is not available brings his tribes closer to trashing RPMS. Right now Alaska has six Tribal locations looking at purchasing something else because they don't have an adequate IHS billing package available to them. Rich's concerned with the availability of a Health Information Exchange.

- Dr. Cullen: People need to realize that even if we get a license agreement, PAMS has not been certified and we have made it public that it will take 6-9 months to get it through the certification process. There are also no funds in the 08 budget to deploy it even it if is certified.

Action Item: None

VistA Imaging Update

Dr. Mark Carroll, Telehealth Program Director, IHS

See presentation slides located at: VistA Imaging Update 08-08-2007

Discussion

- Bob Adams, Portland Area Clinical Application Coordinator: From a regional perspective, Portland Area VistA Imaging training went great. It is beta test software and many VA sites do not have this software yet. The IHS found lots of bugs in it. They did a remote session successfully. Like Dr. Carroll said, this is a revolving roll-out, and it will be interesting to see what happens in Navajo.
- Dr. Carroll: Portland has done great, and he wanted to clarify that not all of the software is beta.

Action Item: None

Electronic Health Record

Dr. Howard Hays, RPMS Program Manager, IHS

Handout can be found at: RPMS Update 08-08-2007

EHR Status
At the present time, 106 sites have implemented EHR. The IHS has already reached the target for 2008 and still has a month and a half to go. We will exceed our goals this year. Areas have taken on the responsibility to deploy the EHR. Their Clinical Application Coordinators (CAC) have done a tremendous job and they were put in for an IHS Director's national award. Tribal sites asking OIT for EHR need to go through Areas. All EHR guides are on the FTP public site, tribes can access these. EHR Version 1.1 release date is not a hard date. We need to have sites taking their WebEx training now if they have not had it.

Geoffrey Roth referenced a national Behavioral Health workgroup that has IT questions. They do not have access to Dr. Hays' information and invited him to their meeting. Dr. Hays will put them in contact with Denise Grenier. Dr. Hays said on suicide data, we have had automated suicide forms for the past 2 years. These are being underutilized, and he encourages sites to start using these.

The EHR Program is getting requests for new EHR functions. We have an analyst dedicated to taking these requests, and we have a change management system. Most requests are reasonable and incorporated. We have change management software and have traceability and accountability for history of requests.

Dr. Marquart asked what the composition of the change control board is. Dr. Hays said we have a software developer - Linda Fels, a Pharmacy consultant -Carlene McIntyre, a doctor from Cherokee, and a few others. There is no formal process to nominate, etc. It is not an OIT-governed board. Dr. Hays does not want the EHR Program to be seen as controlling the board. Dr. Cullen said the board is not really transparent, they are out there but not everybody sees them or knows about them. Dr. Marquart has asked programmers then Professional Specialty Groups but they aren't sure what the statuses of

their requests are at any given time. Given the informal discussions on the status that we have out there, we may not want to post these things on the Web. Dr. Marquart just wants the requestor to be able to see the status of their request and know that something is being done on it. Dr. Cullen said we need to discuss this further with the ISAC on how we can make these things more transparent. Dr. Hays wants to make this information available, but we don't have a lot of staff to use right now. Our goal is to make it traceable and accountable.

EHR Lite
Dr. Hays discussed EHR implementation at small sights without ancillary departments, i.e., pharmacy, lab, radiology, being challenging. EHR is order entry at its core and may not be the solution for these small sites that don't have all or portions of the ancillary departments. Dr. Hays believes it will get easier with the EHR enhancements that are coming out and wants to take another look at these six months down the road.

Discussion:
- Dr. Niska: It's frustrating not to have a good pharmacy part of the package.
- Bob Adams: The expense is prohibitive.
- Mike Danielson: Vuecentric Lite may meet many of the small sites' needs.
- Geoffrey Roth: He understands Urban health programs are the "odd dogs." He would think that all the Urban centers would be considered as small. They are getting a lot of push from IHS to install RPMS in their centers. Dr. Cullen discussed IHS activities to get the Urban centers on RPMS and extended an invitation to Geoffrey to participate on this activity's calls with Phyllis Wolfe, Director, Office of Urban Indian Health Programs and OIT.
- Dr. Cullen: Discussed whether IHS needs to focus resources on practice management applications. The IHS has focused on population health and clinical indicators and done a great job on this, but do we need to now focus on our billing side of the suite of applications? Reece Sherrill asked if IHS will be putting actual billing into our contract proposal responses, (he gave an example of comparing three proposals' billing results). Dr. Cullen said the Dental Program did this. Dr. Cullen would like to impose the software infrastructure that we have imposed on population health onto practice management.

Diabetes Data Funds for 2007
All Areas have been notified of the availability of funding provided by the Division of Diabetes Treatment and Prevention for IT infrastructure enhancements and EHR deployment. Only one Area has provided a complete response to date. Funds will be disbursed as acceptable responses are received. Requirements include:
- Update of 2006 spending plan with actual use of funds
- Identification of Area Clinical Application Coordinator(s) by name
- EHR deployment plan for any remaining Federal sites by the end of 2008
- Spending plan for 2007 funds

Action Item: None

IHS IT Budget Line

Bernie Daillebоust, Director, Division of Enterprise Project Management, OIT

Presentation materials can be found at:

IT_Line_Item_Discussion 08-08-2007
IT_Line_Item_Talking_Points_08-08-07

Bernie prefaced the presentation as informational and no decision is expected at this time.

Discussion:

- Bernie Dailleboust: This proposal will probably require Tribal consultation.

- Reece Sherrill: Did OIT run the numbers for the 4.6 percent. Dr. Cullen said yes, we are only spending about 2 percent of our total IHS budget on IT. We just issued our third data call for Area information and the figure is getting more accurate.

- Dr. Cullen: When we ask HHS, they are reticent to recommend this. Reece Sherrill asked if we could use this as leverage to increase our budget in its current state (without a line item for IT). Dr. Cullen said yes. Reece Sherrill asked if it would help if the ISAC went to Secretary Leavitt directly (the Co-Chairs). Dr. Cullen said it couldn't hurt. Skip Leader said the Secretary is an accountant by trade; you want to be careful what you ask for because you could get it. We only want a line item if it increases the budget.

- Geoffrey Roth: It might be better to be under the radar than out there for all to see. Making an issue of IT budget may not be very well received when IHS can't fund Contract Health Services because their budget is spent after June 1. Dr. Cullen said the best we can get out of this is a good picture of our under-funding.

- Reece Sherrill: Asked what best way to use this would be, comparing and contrasting the private sector versus what we are doing at IHS, and to whom could the ISAC present the information. Dr. Cullen recommended presenting it to Dr. Grim.

- Reece Sherrill: Asked if we would know what to do with the increase and how to execute it. Dr. Cullen said yes, we are getting very good at contracts and would be able to do this.

- Madonna Long: Would the funds come from within our existing budget? Is this what the 4% would be based on? Dr. Cullen said Yes. Madonna said it has a negative impact on patient care. The mandates we already deal with are taking away from patient care. The ISAC is hesitant to ask for something that would have a negative result on our budget.

- Dr. Hays: There are gray areas on what would be deemed IT and what is not. Some areas are between program and IT.

- Dr. Marquart: Is after advocacy. We don't have to necessarily ask for a line item, we can demonstrate under-funding of our IT program.

- Geoffrey Roth: The ISAC has to talk about it in terms anyone can understand, not acronyms, and in patient outcomes. Clark added the ISAC needs to talk about it in the terms Madonna discussed, in relation to patient care.

- Skip Leader: Suggested on the next ISAC agenda, the ISAC come up with an advocacy agenda. Dr. Cullen said OIT could provide a briefing paper for ISAC to use in deciding what they want to advocate for. Barbara Hudson said she has a list of priorities, a given staff, and she just provides a list of the things she is not going to do. She added IHS cannot lobby on the Hill. We display what we can do with the resources we've been given to Dr. Grim and the Secretary. The ISAC recommended the OIT develop a briefing paper of what they can/cannot do, based on funds available. The paper will demonstrate the effect on patient outcomes based on lack of resources. Skip Leader added the ISAC needs to develop a plan on how they can distribute the information.

- Reece Sherrill: Asked how it would be perceived if the ISAC asked to meet with Secretary Leavitt. Dr. Marquart said this group was appointed by Dr. Grim and doesn't want to be seen as going around him. Geoffrey listed a few other groups including Diabetes and the Indian Health Care Improvement Act workgroup that are meeting directly with HHS. Reece said he could do this in his Tribal role instead of ISAC. The ISAC members can distribute the briefing paper to their constituents to use as they see fit.

Bernie said if ISAC members would like to discuss the IT line-item issue more, to send him a message and OIT could send out to all the ISAC.

Action Item:
The OIT will develop a briefing paper of what they can/cannot do, based on funds available. The paper will demonstrate the effect on patient outcomes based on lack of resources.

iCare

Cynthia Gebremariam, Data Networks Corporation

Presentation materials can be found at:

iCare Presentation 08-08-07.ppt
Master_Training_Schedule_for_iCare_cg.doc
iCare_Fact_Sheet_(FINAL).pdf

Discussion:
- Is iCare in EHR? Dr. Hays said iCare runs independently of EHR. Both use the same database.
- Cynthia Gebremariam: The OIT has trained over 1,000 and iCare was well received in the field. Training is available on the IHS Website and the OIT is happy to train groups. She attends conferences to make persons aware of iCare
- Dr. Hays: Gave a presentation in the Aberdeen Area and they had one site that was using or aware of iCare. He presented in Oklahoma and several of their sites were using iCare.
- Rich Hall: Asked how long it took to load iCare. He is concerned about whether he will be able to process 6,000 encounters every night without bogging down his system. Cynthia referred him to Proxicom.
- Dr. Cullen: Asked if Alaska would be interested in testing iCare. Rich said yes.

Action Items:

1 - OIT will send the iCare data to ISAC. (Completed via ISAC listserv e-mail message from Christy Tayrien dated 08/08/2007)
2 - Cynthia Gebremariam will follow up with Rich Hall on the possibility of testing iCare in the Alaska Area.

Computerized Public Health Activities Data-system (CPHAD)

Mary Brickell, Portland Area IHS

Presentation slides can be found at: CPHAD_for_ISAC.ppt

Discussion:
Dr. Marquart: CPHAD ca be used as a tool to account for public health activities, and how to show that not all time is spent on individual patient encounters. Portland uses this to collect time spent. They presented to the nursing group in Spokane last month, who are very interested in CPHAD.

Barbara Hudson: How do we see CPHAD being used? Dr. Marquart said it is really a powerful tool to show how we are a public health agency. We are not like Blue Cross/Blue Shield providing individual care. It is also useful for managing groups of employees i.e., Public Health Nurses and other groups. It could be used for staffing plans for new facilities.

Action Item: None

Information Security Program Update

Kathleen Federico, Director, Division of Information Security, OIT, IHS

Presentation materials can be found at:
SecurityProgramOverview_for_ISAC.ppt
Network_Operations_Security_Center_Brief_6-12-07(R1).ppt

Action Item: None

Electronic Record Policies

Barbara Hudson, Office of the General Council (OGC), IHS Branch Chief, Public Health Division
Mechelle Johnson-Webb, OGC, IHS Public Health Division

The following notes summarize an open, informal discussion between the ISAC and OGC staff:

- Barbara Hudson: Came to the ISAC meeting to learn. She wanted to see how attorneys can be helpful to the ISAC. She gave a brief history of her government career and said she is now in an office in Rockville with a staff of eight. Their work is prioritized as follows:
  1 - If Dr. Grim asks
  2 - If a Judge asks
  3 - If Congress asks
  4 - Getting out and providing legal advice on day-to-day operations; helping offices evaluate litigation risks, and to stay in the confines of the law.

  Ms. Hudson brought Mechelle Johnson-Webb, a Commissioned Officer who has an MPA and JD with her. Mechelle has a sound public health background. They prepared for the meeting by reading a stack of material and added we speak a new language with IT. Both emphasized they are here for us if we need any assistance.

- Mechelle Johnson-Webb: Spent the last two weeks preparing for the meeting. There are legal risks that can potentially come up in implementing an EHR. The law lags behind technology. Someone made the suggestion yesterday from Modern Healthcare to get IT involved first. She recommends getting legal council involved early on as well to prevent legal ramifications down the road. Legal risks include privacy, improper disclosure, abuse of information, shared in a manner not entitled under agreements, and persons using info for illegal or personal uses. Research finds persons inadvertently releasing Personally Identifiable Information (PII) when it's supposed to be an aggregated data set. These are violations to Federal and State statutes as well as common law.

- Dr. Cullen: Asked about sensitive patient tracker and an audit log. She doesn't think anybody knows what to do with the log. We have a dialogue on the EHR listserv discussing the issue right now. The field may not realize the power of this tool.
- Mechelle Johnson-Webb: It could be a Human Resources (HR) issue if someone has access; it could also be an organizational liability if you are aware of this and someone's information is shared.
- Madonna Long: Knows of an instance in Oklahoma where HR disciplined an employee based on the audit.

- Mechelle Johnson-Webb: One thing that is important -- laws that cover the paper record apply to electronic records. We need a strong policy in place. Access is a need-to-know basis.
- Dr. Cullen: From a CIO perspective, there is a real issue in the field. Example used on listserv is the employee relative looking at relative's medical record.

- Madonna Long: It comes down to proof and a need to know. Most of employees have to look at the information, from Medical Records to Contract Health Services. What is the allegation, can you prove undisclosed access?
- Mechelle Johnson-Webb: The organization may know of a breach.
- Dr. Cullen: It's the listserv banter.
- Reece Sherrill: His organization knows about his transplant, his staff is militant that the persons who access his record have a need to know.
- Skip Leader: The audit runs automatically, we don't have time or ability to review the massive information.
- Dr. Cullen: Gave the example of us being able to provide pornography abuse, we have been told our job is to find the abuse and pass the information on.
- Mechelle Johnson-Webb: This is something we need to look at.
- Madonna Long: When HR in her locations find these breaches, they are hesitant to take action, consider discipline too harsh in most cases.
- Barbara Hudson: There are instances of persons being fired for pornography use.
- Dr. Cullen: Very infrequently. Where does the IT responsibility lie?
- Mechelle Johnson-Webb: It's a collaborative effort, have to work as a team to address these issues.

- Mike Danielson: On outpatient consent, the impetus is to have data exchange between facilities and other entities (fed/Tribal).
- Barbara Hudson: They are working on this today, with facilities wanting to electronically talk to each other.
- Mechelle Johnson-Webb: We need to work on this very aggressively, need informed consent on record.
- Mike Danielson: How frequently do we need to do this?
- Mechelle Johnson-Webb: We need to look at and get more clarification on when the consent needs to be obtained. She gave examples of Telehealth providers and facility to facility. This is something we need to look at and discuss at a future meeting.

- Barbara Hudson: We should feel free to call and ask for their advice.
- Reece Sherrill: As a Tribe they work with OGC on issues. Is this opportunity there for them to exercise?
- Barbara Hudson: They should use their own legal counsel.
- Reece Sherrill: Their counsel doesn't have a health background.
- Barbara Hudson: Her office can provide advice to IHS and Dr. Cullen who can pass it on.
- Dr. Cullen: What we know from the past year's research is Tribes own their data. We have to look at health information exchange agreements and make sure they are in compliance with law.
- Reece Sherrill: This has tanked some of their agreements on a tribal level.
- Mechelle Johnson-Webb: It would be worth a Tribe's time to get their attorneys trained in this area or to hire outside counsel that has this background. They need to be knowledgeable in security, system risk, Stark and Anti-Referral laws, and contracting issues.
- Barbara Hudson: She is available to discuss without having to go through the formality of a legal opinion.

- Mechelle Johnson-Webb: Discussed the standard of care we have looked at in previous years. It used to be local but it has potentially changed with the broadness and advent of new technology. Is there a risk because of physicians/providers having to take the time to learn the new technology? Studies in California have shown morbidity rates have increased and associate this with providers having to take time to learn. We also need to look at the risks to the system when it goes down, how secure is the electronic record. The scan of the medical record is another issue.

- Mike Danielson: Asked about the paper record when it is scanned in, and is the EHR the legal medical record.
- Mechelle Johnson-Webb: The law has not caught up with this.

- Pat Gowan: We don't have approval for NARA to store the EHR, we scan the paper into the EHR, but we cannot destroy either of the two. It may be a few more years before we get approval to archive the EHR, it took VA about 10 years to get this approval.
- Dr. Cullen: Nobody is pulling a paper record.
- Pat Gowan: We will have to work with this hybrid.
- Barbara Hudson: Just as they have been involved in other areas such as bioterrorism, emergency preparedness, etc, they are available to us to provide advice.
- Madonna Long: Sees this as a repetition since medical records and health information management and privacy officer have already done quite of bit of the background research on this.

- Dr. Cullen: Discussed the provider being driven by the threat of suit.
- Mechelle Johnson-Webb: We still need to work closely with the IHS legal staff.
- Pat Gowan: They have been working with the regional attorneys; they consult with them and the Privacy Officer. On inappropriate corrections to the EHR, we have so many persons with access to the record. We want to think about this area. We comply with the Rules of Behavior. One of the 14 rules is on the corrections. Hopefully in the next two months they will have these ready.
- Mechelle Johnson-Webb: You don't want to risk your organization's reputation on these liabilities. Tort claims need to be considered in the EHR.

- Dr. Cullen: The data sharing issue is still there and we are looking at this. Are Tribes considered as a part of IHS?
- Mechelle Johnson-Webb: They are separate from the IHS, but they are covered entities under HIPAA.
- Mike Danielson: On the data we aggregate nationally, are there are any legal implications? Do patients need to give consent for their information to be included?
- Dr. Marquart: Has brought this issue to the table for years. Researchers wanted to pull data from the National Data Warehouse to analyze cancer in patients just last week. They were told they have to go through the Area they are studying and complete an Institutional Review Board. We don't have clear policies to guide us on this.
- Reece Sherrill: We have epidemiology centers doing the same research.
- Dr. Cullen We need to get some policies in place on this, especially with the Master Person Index coming.
- Rich Hall: Alaska has had a state-wide sharing database since the 70s.

Action Item: None

Electronic Master Person Index

Mike Danielson, Director, Division of Information Technology, OIT, IHS
Rich Hall, Alaska Area

Presentation slides can be found at: EMPI-ISAC.ppt

Action Item: None

United Financial Management System

Mike Danielson, Director, Division of Information Technology, OIT, IHS

Presentation slides can be found at: ISAC_UFMS_Update.ppt

Discussion:
Reece Sherrill: Asked about cash transactions like payment for services (example, cafeteria). Mike Danielson will look into it.

Leslie Racine: Asked about credit card payments. Mike wasn't sure.

Michael Belgarde: the UFMS Help Desk Plan has different tiers than the RPMS help desk and said this may create confusion at local levels.

Madonna Long: iProcurement has a 24-hour help desk through Bearing Point.

Action Item: None

Electronic Dental Record (EDR)

Dr. George Chiarchiaro, Project Manager, IHS/EDR

Discussion:

- Reece Sherrill: Asked about Tribes participating and their positions on the queue. Dr. Chiarchiaro said they ware working on developing a process where both Federal and Tribal sites that wanted to implement the EDR can get it without having to wait unnecessarily. They would participate with their own money

- Chuck Walt: Asked if Dentrix was going to be made available to Tribal sites that are not on RPMS. His site has been using Dentrix for 5 years, but they are not on RPMS. This could potentially save on licensing, etc. Dr. Chiarchiaro said yes.

- Chuck Walt: If running Dentrix, will Tribes have the ability to submit local dental information to the National Data Warehouse independently as non-RPMS users? Dr. Chiarchiaro said he thought this was addressed by the National Data Warehouse somewhere.

- Chuck Walt: Asked about the interface being bid separately, thought this would be in the initial contract. Dr. Chiarchiaro said there are two parts to the interface -- the RPMS side and Dentrix side. The Dentrix is doing their interface.

- Chuck Walt: On payment of software licensing agreements, will Tribal sites be eligible for this? Dr. Chiarchiaro said all sites, Federal and Tribal, will have to pay for their own hardware. All other costs would be covered. If sites want to participate in the national implementation without having to wait, they will have to fund all costs involved.

- Dr. Marquart: Asked about the initial plan providing the servers for the first 10 sites. Dr. Chiarchiaro said they lost $1.6 million last year and can't provide the servers anymore.

- Dr. Marquart: asked about annual software costs. Dr. Chiarchiaro said the original proposal cited $600 per site per year.

- Dr. Cullen: Asked if they knew for a fact that they needed a dedicated server. Dr. Chiarchiaro said yes. Dr. Cullen said there should be room on existing servers.

- Dr. Marquart: Asked about the EDR having to be run in parallel with the EHR and use of the RPMS dental package. He asked if any consideration had been given to revisiting the VA EDR solution. Dr. Chiarchiaro said it did not meet our requirements.

- Reece Sherrill: Will you have the option to run the RPMS dental package? Dr. Chiarchiaro said no, Dentrix will replace it.

- Madonna Long: Asked about ordering meds. It's very expensive to develop an interface with Pharmacy 7, and dentists will have to enter the order in the EHR. Reece Sherrill asked what the

interface does. Dr. Chiarchiaro said Patient Registration will interface with PCC for billing and claims generation and the RPMS Patient Scheduling package to see if a patient has a medical or dental appointment, and provide Clinical Notes capability.

- Chuck Walt: Dentrix has its own billing package, asked if sites will be using it. Dr. Chiarchiaro said it would be a local decision. Reece asked which package would be more up-to-date.

- Madonna Long: Where is the return on investment? Sites are being tapped for every new IT requirement. Is this optional? She would like to see what the earned value is on these requirements like Dentrix and UFMS. Dr. Cullen said the Information Technology Investment Review Board process may have a flaw. The server cost was not readily seen in the business case, and this affects the return on investment. Reece Sherrill said it was grouped into hardware costs that sites will be responsible for, and didn't see it. Skip Leader said the server costs will be substantial in out-years.

- Dr. Marquart: Concerned with the $1.6 million dollars the EDR investment lost, and if we will need to anticipate losing any more funds over the next five years, or having additional costs the local facilities will have to bear. Dr. Chiarchiaro said we had these funds in a Mitretek contract we couldn't get back.

Action Item: None

Clinical Application Coordinator (CAC) Resource Requirements Methodology

Leslie Racine, CPC, Program Analyst

Presentation slides can be found at: ISAC_ITRRM.ppt

Leslie reported putting the Clinical Application Coordinator (CAC) in Clinical on the IHS Resource Requirements Methodology (RRM) was not well received. The statisticians are asking that IT support the CAC. The ISAC agreed to support the RRM Technical Advisory Committee (TAC) working with appropriate subject matter experts to develop a formula for inclusion of the CAC in the RRM. Leslie will verify who will be giving the formal presentation to the RRM TAC.

***Action Item: The ISAC Co-Chairs will write a letter of support to the RRM TAC stating* "The ISAC supports and recommends the IHS RRM TAC working with appropriate subject matter experts to develop a formula for inclusion of the CAC in the RRM."**

ISAC Discussion

ISAC Priorities Update

Dr. Theresa Cullen, IHS Chief Information Officer

See presentation slides located at: CIO_Update-ISAC_08-08-07(TC).ppt

Dr. Cullen continued the CIO presentation she began on Day 1 by discussing the status of IHS accomplishments on ISAC priorities. Discussion follows:

- Priority #1: ELECTRONIC HEALTH RECORD: Dr. Hays' earlier presentation provided an update on this priority.

- Priority #2: BILLING: Reece Sherrill: Had a constituent ask whether HHS had the authority to require IHS to participate/purchase enterprise mandates when IHS is under the Department of Interior's appropriation. The ISAC discussed the possibility of their Tribal constituents investigate this issue further.

- Priority #3, DATA QUALITY/ACCURACY: Certification and Accreditation for non-RPMS systems will affect data quality.

- Priority #4 TRAINING:
  - Skip Leader talked about the poor relations with his Area Office, and the helpfulness of the Headquarters Helpdesk being the reason Tribes take their Area shares but leave the Headquarters share.
  - Mike Danielson: Referenced the virtual centers of excellence concept that was promoted a few years ago, but it never went anywhere.
  - Reece Sherrill: recommended Podcasts for Training.
  - Dr. Marquart: on Computer Security Awareness Training, 15 modules are too many.
  - Dr. Cullen: We need to look at what the minimum requirements are, not how hard or lengthy we can make it.

- Priority #5: TELEMEDICINE COORDINATION: Dr. Carroll's earlier presentation provided an update on this priority.

- Priority #6: MASTER PERSON INDEX: Mike Danielson's earlier eMPI presentation provided an update on this priority.

- Priority #7 DECISION SUPPORT SYSTEM: Dr. Cullen said there are no funds for this. We may get $100,000 from AHRQ to be used toward this but not sure at this point.

- Priority #8 INFRASTRUCTURE/ARCHITECTURE: Dr. Marquart requested that the overall IHS strategic plan take into account what is in the IHS IT strategic plan. Dr. Cullen will have OIT take all the IT related requirements out of the overall strategic plan and share with the ISAC.

- Priority #9 COST ACCOUNTING: ISAC discussed whether this item is on cost centers or cost of service and what ISAC considers the priority.

- Priority #10: SECURITY: Kathleen Federico's earlier presentation provided an update on this priority.

ISAC ACTION ITEMS

Action items referenced throughout the minutes are presented here in one section for your convenience:

1. ***Health Information Technology Committees/Workgroup Volunteers:*** *The OIT will send ISAC the HIT workgroup volunteer message from Dr. Cullen. (Completed via ISAC listserv e-mail message from Christy Tayrien dated 09/26/2007)*

2. ***ISAC Permanent Urban Representative:*** ISAC Co-Chairs will send a letter to Geoffrey Roth clarifying that Geoffrey is the permanent ISAC urban representative.

3. ***Clinical Informatics Management Technical Advisory Committee:*** The OIT will follow up with Dr. Hays to distribute to the ISAC any feedback on the Clinical Informatics Management Technical Advisory Committee's EHR Lite discussion at their upcoming meeting and any information from the Lab PSG on the lab issue being a local problem.

4. ***Resource Requirements Methodology:*** The ISAC Co-Chairs will issue a written recommendation to the Director, IHS, on the Clinical Application Coordinator inclusion in the RRM ***stating*** **"The ISAC supports and recommends the IHS RRM TAC working with appropriate subject matter experts to develop a formula for inclusion of the CAC in the RRM."**

5. ***Information Technology Line Item:*** *The OIT will develop a briefing paper for the ISAC to share with their constituents of what they can/cannot do, based on funds available. The paper will demonstrate the effect on patient outcomes based on lack of resources.*

6. **iCARE:**
   a. *OIT will send the iCare data to ISAC. (Completed via ISAC listserv e-mail message from Christy Tayrien dated 08/08/2007)*

   b. *Cynthia Gebremariam will follow up with Rich Hall on the possibility of testing iCare in the Alaska Area.*

7. **HHS Mandates:** Reece Sherrill will draft a letter on the question about IHS having to participate in HHS mandates since our funding comes from the Department of Interior. The letter will go to the National Indian Health Board and the Direct Service Tribes Chair.

8. **ISAC Action Process:** The ISAC will develop an Action Item Process for ISAC.

ISAC Meeting Schedule

The ISAC set their next meeting November 14-15 in Tucson, Arizona. The OIT will follow up with the Tucson Area IT staff on space and logistics.

Meeting Adjourned